STATE OF CONNECTICUT
STATE TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106
In CT 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018
www.state.ct.us/trb

Aetna Health Plans Rate Increase
October 29, 1999

Dear Aetna US Healthcare Subscriber:

Aetna US Healthcare has announced rate increases for the Connecticut Teachers' Retirement Board Plans effective January 1, 2000.

CTRB Aetna Plan Subscribers will now be required to have a health insurance premium deduction taken from each monthly benefit starting December 31, 1999.

AETNA US HEALTHCARE CTRB PLANS
MONTHLY RATE INCREASES
JANUARY 1, 2000

PLAN TYPE	INDIVIDUAL	INDIVIDUAL + SPOUSE
Aetna HMO with Dental	$68.90	$137.80
Aetna POS without Dental	$92.80	$185.60
Aetna POS with Dental	$106.90	$213.80

(CONNECTICUT RATES)

To retain Aetna coverage no action is necessary. The monthly premium deduction will **automatically** be deducted from each monthly benefit payment beginning December 31, 1999.

To cancel Aetna coverage, each enrollee must complete a cancellation form and return to this office **no later than December 10, 1999.**

To enroll in one of the CTRB Medicare Supplemental Plans, each enrollee must complete an Aetna cancellation form **and** a CTRB Medicare Supplemental Insurance Application and return to this office **no later than December 10, 1999**.

No changes will be accepted after the December 10, 1999 deadline.

This is your final opportunity to make a change in the health plan for yourself and/or your spouse before the open enrollment date is announced.

Enclosures:
- Health Insurance Policy Change Announcement
- CTRB Medicare Supplemental Insurance Applications (2)
- Aetna Cancellation Forms (2)

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CANCELLATION FORM

Teachers' Retirement Board and Aetna U.S. Healthcare:

I am writing to notify you that I wish to cancel my coverage with Aetna U.S. Healthcare's Golden Medicare Plan.

My name is: _____

My Aetna U.S. Healthcare ID Number is: ME_____

My Social Security Number is: _____

My Address is:

_____

_____

My Phone Number is: (_____) _____

I am requesting that you disenroll me from the plan the First Day of:

_____(Month/Year)

_____(Signature)_____(Date)

Mail to:

CTRB
21 Grand Street
Hartford, CT 06106

CTRB WILL FORWARD A COPY OF THIS CANCELLATION REQUEST DIRECTLY TO AETNA U.S. HEALTHCARE